case there was complete pyloric obstruction at a time when the regional lymph glands showed no metastases. The patient was in extremis, consequently posterior gastro-enterostomy was performed with the Murphy button, the intention being to relieve the obstruction for purposes of nutrition. When the gastro-enterostomy had been completed, however, the patient being no more depressed than when the operation began, she having absorbed large quantities of salt solution, pylorectomy was performed, cut ends of the stomach and duodenum being invaginated with three rows of silk sutures. Microscopical diagnosis by Dr. Ophuls showed carcinoma limited to the pylorus, no metastases in regional lymph glands. Patient rapidly recovered and ever since has been in excellent health. Dr. Rixford said that examinations of the gastric juice before operation showed the presence of free hydrochloric acid in nearly normal amount.

Excision of Vocal Cord for Epithelioma. Dr. Rixford presented a case in which the tumor was a fungating epithelioma occurring from the anterior half of the vocal cord; it had caused almost complete aphonia; it was removed by splitting the larynx in the middle line with the head hanging over the head of the table. Exposure was excellent and the tumor was lifted bluntly from its bed, taking nearly the whole of the right vocal cord and cellular tissues about it. The wound was then cauterized with the thermo cautery, by which all bleeding was stopped. Wound was then closed; the hyoid membrane sutured as well as the perichondrium of the larynx, but the superficial wound was drained in order to furnish free exit for infectious discharges. There was very little reaction and patient made a rapid recovery. For some weeks patient could blow air through the drainage opening but this finally closed. Patient's voice has been gradually improving until now he can be heard across a fairly large room. Of course the left vocal cord is performing most of the function of phonation.

Compound Pott's Fracture and Dorsal Dislocation of Great Toe. Dr. Rixford exhibited a young man, police officer, who in collision with an automobile two years ago received a compound Pott's fracture, all of the ligamentous structures on the inner side of the joint being torn, and the tibia ground into the dirt of the road, and the tibio-fibular ligaments widely torn. He also sustained dorsal dislocation of the great toe of the other foot, Colles' fracture at one wrist and fracture of the lower end of the ulna at the other. The lateral and capsular ligaments were sutured and the foot fixed in plaster of paris, joint drained. Prophylactic dose of antitetanic serum was administered. Primary union occurred with the result as exhibited; after two years there is no lack of stability in the ankle, no widening but flexion is limited to a right angle, while extension is normal. Reduction of the dorsal dislocation of the great toe was effected only by means of open operation. Stimson's suggestion of cutting the capsule subcutaneously by means of a tenotomy did not release the phalanx although everything between the skin and the metacarpal bone was cut on the dorsal and inner side. On opening the joint the head of the metacarpal was found to protrude between the abductor of the great toe and the inner head of the flexor brevis muscle; the flexor brevis and longus with both sesamoid bones were thrown up into a vertical position on the outer, that is the fibular side of the first metacarpal. Reduction was effected only when the flexor tendons with the sesamoid bones were lifted off the enlarged end of the metacarpal by a blunt instrument used as a lever. Reduction was then immediately effected. Primary union occurred with a perfectly movable joint but with some defect in abduction of the great toe leading to a mild degree of hallux valgus. This case is important in relation to the difficulties of reduction of the dorsal dislocation of the great toe and thumb. All text books state that the resistance to reduction is caused by a flap of the capsule of the joint slipping over the head of the metatarsal or metacarpal to be relieved by pushing the hyperextended phalangeal downwards parallel to the direction of the metatarsal. In this case this manoeuvre utterly failed as did also subcutaneous section of the capsule.

Dr. Sterling Bunnell presented a man who five weeks previously had been rolled between a car and a wall, injuring ribs and the pelvic and shoulder girdles. There had been a comminuted fracture of the left humerus above the insertion of the deltoid muscle which could not be reduced satisfactorily by conservative methods as the pectoral, coracobrachialis and deltoid muscles each pulled a separate fragment of bone. An open operation was done and the fragments were brought together with a wire and a staple into their original alignment as shown by the X-ray plate and normal appearance of the arm. On the other side the man's clavicle was dislocated from his acromial process and could be seen projecting upward beneath the skin. This rather unusual dislocation prevented the arm from rising above the horizontal and caused pain in lifting vertically with the arm. These dislocations uniformly become worse if not treated by the open method. A similar dislocation was operated upon by Dr. Bunnell with good result. Wire was used and afterwards removed as it caused some pain in this movable joint. Kangaroo tendon is to be preferred and will be used on this man.

Section on Surgery, Sept. 19, 1911.

By H. B. A. KUGELER, M. D., San Francisco.

Mrs. Miller, 47 years of age. Widow. One child. lives in Newman, California. She came to me in 1901 with symptoms of exophthalmic goitre of one year's standing. Having just returned from Europe where I heard Rehn's paper on "One Hundred and Thirty-Five Collected Cases Treated by Operation," reported at the meeting of the Deut. Naturf. Aertze in Munich, and also heard the critical discussion, I put her on the then usual treatment of inunctions with red oxid of mercury ointment and bromides and belladonna internally.

A year later she returned with the symptoms aggravated and I removed the right lobe of the thyroid. Her condition was materially improved as shown particularly in her letters which were in German script, the lines becoming steadier with each letter. The subjective symptoms also improved.

On July 25, 1911, she returned, stating that for the past two years she had been more nervous than formerly and that her heart was more rapid. She had pneumonia one year ago. Two months previous to her visit her legs became greatly swollen and she still had some edema. The heart was very rapid, running from 140 to 150, with a reduplication of the second sound. She was put on tincture digitalis 10 drops, tincture belladonna 5 drops every 4 hours.

On July 27th, she returned somewhat improved, pulse still 120 but the reduplication was gone.

The improvement was not permanent and on the 15th of August I ligated the superior pole of the left lobe under Schleich, making a transverse incision. She stood the operation very well. The next morning her pulse was 90. That afternoon she had a chill and by 4:30 her temperature was 104.2. Thinking that it was more the result of an acute hyperthyroidism, and remembering Forschheimer's treatment for exophthalmic goitre as mentioned in Ochsner's work on the thyroid, I gave her gr. 5 bromide of quinin suspended in syrup of yerba santa.

The next morning her temperature was normal, but as a precaution I gave her another dose on the 17th and one on the afternoon of the 18th, but the temperature remained normal. Her pulse ran between 80 and 90 while in the hospital and she went home in 2 weeks.

On the 5th of September she was very much improved, but thinking to hasten the improvement

I put her on the bromide of quinin gr. 5 three times a day in pill form.

Specimen Presented. Mrs. Stevenson. 54 years of age. Widow. Two daughters. Husband died when she had been married only 4 years and she has worked very hard all her life to support herself and children. Some years ago she was told in Iowa that she had a fibroid of the uterus. A similar diagnosis was made in San Francisco.

On the 28th of August, while lifting a mattress, she felt a pain in her right iliac region. She had occasional spells during the day, and at three o'clock in the morning of the 29th was taken with a very severe pain and vomiting which continued. I saw her in the afternoon. There was marked tenderness in the lower abdomen, a palpable tumor exquisitely tender; still nauseated; no bowel movement; no temperature. She was removed to St. Mary's Hospital with a provisional diagnosis of a fibroid with a twisted pedicle.

Aug. 30th, operation: Before the peritoneum was opened, a dark mass was seen which on palpation fluctuated and the diagnosis was changed to strangulated ovarian cyst. There was some dark, free blood in the peritoneum; the cyst was lifted out entire; an intra-mural fibroid was found in the uterus, and as on palpation a polyp had been felt projecting from the cervix, a complete hysterectomy was performed.

Patient was up on the 10th day and left the hospital on the 14th day.

On splitting the uterus its cavity was found to be filled by a polyp whose pedicle was attached to the fundus.

Mr. G. U. Patrick. Was seen by me in consultation with Dr. R. J. Nicholls on July 29, 1911. Patient is 38 years of age; a miner; married; no children. His father was killed in a mine at the age of 42. His mother died at the age of 22 in confinement. No brothers or sisters. The only sickness he remembers before the present trouble was ptomaine poisoning from shrimp salad in January, 1910. He was very sick for one night and had bowel disturbance until July, 1910.

His present trouble started in December, 1910. He never had a diarrhea, never had dysentery or typhoid fever. Severe pains and constipation began in March, 1911. He complained that riding in a buggy or a car brought on attacks of pain in the right side. These lasted for an hour or two and then disappeared under massage. These attacks occasionally occurred without any exciting cause. He found that when these attacks were on a lump formed in the right iliac region, which disappeared on rubbing.

On examination this phenomenon was observed; a mass forming in the right iliac region, but also in the right hypochondriac following usually the disappearance of the former. He was sent to the German Hospital, the lower bowel inflated, and it was found that the abdominal cavity below and to the left of a line drawn from the tip of the left 8th rib to the right anterior superior spine of the ilium, became inflated and produced pain. From that we concluded that the transverse colon was attached somewhere in the right iliac region. Gastric analysis gave the results usually accompanying carcinoma of the stomach with the exception of the absence of blood. A series of X-ray pictures, taken after the ingestion of bismuth gruel, showed that there was an obstruction on the right side, where the bismuth was partly retained.

August 3d, operation: An incision was made in the outer border of the right rectus muscle; a small, hard mass was palpated, not very movable owing to adhesions passing across the transverse colon. These were liberated and the proximal end of the colon was so distended and thickened as to resemble the stomach. The appendix was very long and distended with fecal matter, evidently due to backward pressure. The mass in the transverse colon was resected; the two ends brought together with large Murphy button.

The lymphnodes attached to the mass were sent to Prof. Ophuls, who reported no tumor; diagnosis—catarrhal lymph-adenitis. The piece of bowel was then submitted for examination and the report came carcinomatous ulcer of the colon.

Patient developed an ether pneumonia but responded promptly to a few hypodermics of digalen.

On the 9th day patient was up.

On the 11th day a Roentgen picture revealed the Murphy button still in situ, and the patient left the hospital.

On the 14th day patient came to the office complaining that his hemorrhoids bothered him. He was given some ointment and told to use cold applications. He returned the following day with the statement that there was an obstruction in the lower rectum. It proved to be the Murphy button, which required removal by forceps.

A letter from Dutch Flat, dated September 2nd, states that the patient is feeling splendidly, has gained 7 pounds, but still takes a little cascara every night for his bowels.

Surgical Section, Sept. 19, 1911.

By JNO. C. NEWTON, M. D., San Francisco.

This is a case of external anthrax. We know that the anthrax bacillus is of special historical interest on account of its being the first micro organism proved definitely to have a specific etiological relationship to an infectious disease. More animals (cattle and sheep) succumb to anthrax than of any of the other diseases affecting them.

This patient came in from the country this afternoon, complaining of swelling and stiffness of his hand and arm and the three pustules seen on his thumb and finger.

The history begins three days ago. The patient is a milker and gives the information that he had assisted in the burying of several cows that had died from some unknown cause. There were slight abrasions on his hand and from these places the condition seen here rapidly developed. His temperature is 101, pulse 112. The carbuncular lesions are capped with characteristic bluish vesicles.

The anthrax bacilli has been demonstrated in smears made from the Sero Sanguineous contents of the vesicles. In the case I previously presented to the society in Sept., '09, which is reported in the State Journal of Jan., 1910, the diagnosis was verified by guinea pig inoculation. I will treat this condition by injecting 0.35 of pure carbolic acid into each pustule and follow this by mild germicidal applications. He is receiving 0.35 each of guaiacol and quinin sulphate internally.

A vaccine will be used if the condition does not yield to this treatment. The prognosis is bad in all forms (Ravenel) and the mortality of external anthrax is variously given at from 5 to 25%. The pulmonary form (wool sorters' disease) is largely fatal.

On the Paralysis of the Abducens of Otitic Origin.*

By VICTOR F. LUCCHETTI, M. D., San Francisco.

At the last meeting of the Eye and Ear Section of the County Medical Society, an interesting case having a symptom complex known as Gradenigo's Syndrome was presented and discussed; and Dr. Welty, chairman of our section, requested me to make an extensive report on the above disease at this meeting. The condition is such a rare and interesting one to the specialist and profession at large from an anatomical and pathological standpoint, that I deemed it advisable to present in full the views of the author regarding this affection.

Prof. Gradenigo does not agree with Citelli that one should speak in a general way of Gradenigo's Syndrome; but rather of a well defined and pathological condition.

* Read before the Eye, Ear, Nose and Throat Section of the San Francisco County Medical Society, Sept. 26th, 1911.